

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1814
Registrar's No. 44

Registration District No. 85
Primary Registration District No. 1001

1. PLACE OF DEATH:

(a) County **BUCHANAN**
(b) City or town **ST. JOSEPH**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **STATE HOSPITAL No. 2**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2 yrs. 1 mo. 11 days**
(Specify whether
In this community **all his life 2 yrs.**
years, months or days)

3. (a) PRINT FULL NAME **William H. Foster**

3. (b) If veteran, name war **—**
3. (c) Social Security No. **None**

4. Sex **Male**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Separated**

6. (b) Name of husband or wife **Not Given**
6. (c) Age of husband or wife if alive **?** years

7. Birth date of deceased. **Jan 15 1850**
(Month) (Day) (Year)

8. AGE: **90** Years **11** Months **26** Days
90 **11** **26**
If less than one day hr. min.

9. Birthplace **Sandusky Ohio**
(City, town, or county) (State or foreign country)

10. Usual occupation **Miner**

11. Industry or business

12. Name **William Foster**
13. Birthplace **?**
(City, town, or county) (State or foreign country)

14. Maiden name **Not Known**
15. Birthplace **Not Known**
(City, town, or county) (State or foreign country)

16. (a) Informant **Frank Quinn**

(b) Address **2636 Wabash, K. C. Mo.**

17. (a) **Removal** (b) Date thereof **1-13-41**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kansas City, Mo.**

18. (a) Signature of funeral director **Walter Meierhoff**

(b) Address **1302 Carson Street**

19. (a) **1-13-41** (b) **H. H. Mestlebach**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Bar**
(c) City or town **Kansas City**
(If outside city or town limits, write "RURAL")
(d) Street No. **2418 East 28th St.**
(If rural, give location)
(e) If foreign born, how long in U. S. A. **0** years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **11**
year **1941** hour **5** minute **40**

21. I hereby certify that I attended the deceased from **Jan 8**
1941, to **Jan 11**, **1941**;
that I last saw him alive on **Jan 11**, **1941**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Bronchopneumonia Bilateral**
Due to **Heart Disease Arteriosclerotic**
Due to **93W**

Other conditions **Arteriosclerosis General**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **—**
Of autopsy **—**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

85 (Specify type of place)
While at work? (c) Means of injury
23. Signature **Herbert C. Linn** (M. D. or other)
Address **2418 East 28th St. Joseph** Date signed **1-11-41**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.

working under my personal supervision.

Signed.....

Licensed Embalmer No.

P. O. Address

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.